DEPART	TMENT OF HEALTH	AND HUMAN SERVICES	with	a. NIS	FORM APPROVED				
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES *	45-	10:7115	OMB NO. 0938-0391				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION / '	(X3) DATE SURVEY COMPLETED				
<u>.</u>		445415	B. WING		07/24/2013				
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CO	ODE				
NHC HEALTHCARE, FARRAGUT			120 CAVETT HILL LANE KNOXVILLE, TN 37922						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE COMPLETION DATE				
F 000	INITIAL COMMENTS		F 000						
F 356 SS=D	During the annual recertification survey conducted on July 22-24, 2013, at NHC Healthcare - Farragut, no deficiencies were cited in relation to complaint #31996 under 42 CFR PART 482.13, Requirements for Long Term Care. 483.30(e) POSTED NURSE STAFFING NFORMATION		F 356	1. On July 22,2013, the required nurse staff	staffing				
	a daily basis: o Facility name. o The current date. o The total number by the following cate unlicensed nursing resident care per sh - Registered nur - Licensed pract	rses. tical nurses or licensed as defined under State law).		data was poster sidents were at this deficient. 2. No adverse out patients were lated to not he required nurse posted at the of the shift. 3. Each clinical charge nurse we the required shift.	affected for cy. comes to found re- naving the e staffing beginning coordinator/ will post staffing				
	specified above on a of each shift. Data of Clear and readable	ce readily accessible to		4. The DON and AD monitor on a pases, to ensudeficient praction not recur.	periodic are the				
	make nurse staffing for review at a cost standard. The facility must ma	oon oral or written request, data available to the public not to exceed the community sintain the posted daily nurse							
	staffing data for a m	inimum of 18 months, or as w, whichever is greater.							
ABORATORY	DIRECTO S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(XG) DATE				
	XQulQ(Xan-e		Administrator	8/7/13				
ny deficienc	y statement ending with a	in asterisk (*) denotes a deficiency whi	ch the institut	tion may be excused from correcting	providing it is determined that				

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: TN4716

PRINTED: 07/25/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445415	B. WING		· · · · · · · · · · · · · · · · · · ·	07/24/2013	
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, FARRAGUT			STREET ADDRESS, CITY, STATE, ZIP CODE 120 CAVETT HILL LANE KNOXVILLE, TN 37922				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	N SHOULD BE CO	
F 356	Continued From pa	ge 1	F:	356			
	by: Based on observatifailed to post accurate as required. The findings include Observation on July first floor nurse's stainformation posted on nursing staff on duty Observation of the pstaffing information scheduled for Friday been updated to reflifacility on July 22, 20 Interview with Registhe observation on Jstaffing information of staffing information of	22, 2013, at 8:35 a.m., at the ation, revealed the staffing did not accurately reflect the for the current day. Dosted staffing revealed, the posted was the staff for July 19, 2013, and had not ect current nursing staff in the D13. Itered Nurse #1 at the time of July 22, 2013, confirmed the did not reflect the current tr, and confirmed the facility					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TFDX11

Facility ID; TN4716

If continuation sheet Page 2 of 2